STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	
MIDILAN	OI CORRECTION	155115	A. BUI	LDING		02/16/	
		133113	B. WIN			02/10/	2012
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
					LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was fo	or the Investigation of	F00	000	The creation and submission of th	is	
	Complaint IN00	103832			plan of correction does not		
	_				constitute an admission by this		
	Complaint IN00	103832 Substantiated.			provider of any conclusion set for		
	•	ficiencies related to the			in the statement of deficiencies, o	or	
		ted at F244, F279, F323			of any violation of regulation.		
	_	ica at 17277, 17279, 17323					
	and F353						
	Survey date: February 16, 2012						
	Facility number:	: 000048					
	Provider number	r: 155115					
	AIM number: 10	00275330					
	Survey team:						
	Sandra Haws, R	N					
	~,						
	Census bed type						
	SNF/NF: 110	•					
	Total: 110						
	Census payor typ	pe:					
	Medicare: 10						
	Medicaid: 77						
	Other: 23						
	Total: 110						
	Sample: 6						
	•						
	These deficienci	es also reflect State					
		accordance with 410 IAC					
	16.2.	accordance with 410 IAC					
	10.2.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

000048

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		A. BUILDING B. WING	— COM	COMPLETED 02/16/2012	
	PROVIDER OR SUPPLIER AL NURSING AND	REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP C LASALLE AVE I BEND, IN 46617	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	Quality review com Cathy Emswiller RI					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 995N11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155115	B. WIN			02/16/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER			I BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0244	483.15(c)(6)	LCDOUD					
SS=E	LISTEN/ACT ON	COMMENDATION					
		or family group exists, the					
		n to the views and act upon					
	-	nd recommendations of					
		milies concerning proposed					
		tional decisions affecting					
		d life in the facility.	F.0.0		_		00/15/2010
		ation, record review and	F02	44	F244 – Listen Act on Group Grievance/Recommendation	14	03/17/2012
		cility failed to ensure			is the practice of this provider		
	•	nces were addressed in a			listen to the views and act upo		
	timely manner re	lated to weekly resident			the grievances and		
	council interview	s that had been			recommendations of residents		
	conducted, repea	ted the same complaints			and families concerning propo		
	and concerns abo	out care and call lights			policy and operational decision affecting resident care and life		
	every week with	no evidence of the			the facility. What corrective		
	grievances being	addressed or fixed			action(s) will be accomplished	ed	
	affecting 2 of 6 s	ampled residents,			for those residents found to		
	_	esident being in a urine			have been affected by the		
	_	hours (Resident # H) and			deficient practice:		
		sident J) yelling for help			As validated by residents # K #L, #M	,	
	,	his deficient practice had			#N, #O, #P, #Q, #R, #S, #T, #U, # V and #Y and by unanimous positive		
		ffect 17 of 17 residents			affirmation as recorded in the		
	•	oncerns during the			resident council minutes dated		
	1	0			03/20/2011, call lights are being		
		meetings. [Residents K,			answered in a much improved and		
		O, N, P, Q, R, S, V, W,			satisfactory manner and CNAs are		
	AND Z]				following through after answering		
					their respective call lights.		
	Findings include	<u>.</u>			In interviews with residents #L, #Q,		
					#Y, #T, #O, staff members are not		
	•	iew with CNA # 3 on			perceived as being rude on		
	2/16/12 at 4:15 a	.m. she indicated she			weekends.		
	works alone with	47 to 49 residents most			In interviews with residents #Z, #L, #T, #H, #I and #O, staff members are	a	
	of the time. She	indicated when she			not perceived as providing poor care		
	comes to work at	10:00 p.m. there's just			while bathing (bed baths) – nor		

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If continuation sheet Page 3 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	ETED
		155115	B. WIN			02/16/2	2012
NAME OF F	DDOMNED OF GUIDNI 150			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1121 E	LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		e scheduled on the 1st			using cold washcloths, nor drying		
		indicated sometimes they			residents improperly, nor poorly		
	have an extra person come in at 4:00 a.m.				squeezing excess water out of washcloths (getting bed wet).		
	to help with getti	ing people up. She			Interviewed residents stated they		
	further indicated	when she comes to work			are being changed in a timely		
	at 10:00 p.m. the	call lights are going off			manner.		
		any of the residents are 2			How other residents having	the	
		care and transfers and			potential to be affected by th	е	
	_	the other residents on			same deficient practice will be		
	•	l or wet themselves.			identified and what correctiv	е	
		N # 5 both indicated			action(s) will be taken: Any		
					resident with a grievance or	_	
		llen because there wasn't			concern has the potential to b affected by this finding. A rev		
	enough staff to a	ssist them on time.			of the facility Resident/Family	CVV	
					Concern/Grievance Log as we	ell	
	During observati	on on 2/16/12 at 4:40			as Resident Council minutes v		
	a.m., a resident	(Resident # J) was			be completed. This review wi		
	observed sitting	up on the edge of her bed			ensure all grievances/concern	S	
	screaming for he	lp. CNA # 3 and LPN #			have been addressed and/or resolved and communicated to		
		busy in other resident			the person initiating the	ا ا	
		ninutes, CNA # 3 heard			grievance. The ED/designee	is	
		sident and ran out of the			responsible for completing this		
	1	o assist the screaming			review. Any unresolved		
		•			grievances/concerns will be		
	resident before si				followed up with at the time		
		nadn't been close enough			noted. In addition, the facility conduct weekly Resident Cou		
	·	vould have fallen out of			meetings in order to ensure		
		3 indicated she's not able			prompt feedback and follow u	o	
	to get to some ca	Il lights for up to 2 hours			from any verbalized concerns	.	
	when they are go	oing off on the other halls.			Residents with		
					grievances/concerns will be		
	Review of the Re	esident Council meeting			queried regarding their satisfaction to the resolution.		
		12 at 9:45 a.m. indicated			What measures will be put in	nto	
	some of the follo				place or what systemic		
					changes will be made to		
	Resident Counci	l minutes dating January			ensure that the deficient		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED	
		155115	B. WING			02/16/	2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	ER			LASALLE AVE			
CARDIN	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	3 2012 with 10	residents signed attending			practice does not recur: A			
		•			mandatory all staff in-service v	vill		
	(Residents # K, # L, # M, # N, # O, # P, #				be conducted on 3/6/12. This			
		# T) indicated the "call			in-service will include review of			
	-	answered, CNA's don't			the facility policy titled,			
	follow through	after answering call			"Resident/Family Grievances and			
	light"				Concerns". This in-service wil			
					include review of the process f resolution of grievances and	UI		
	January 10, 201	2 with 7 residents signed			concerns as well as prompt an	nd		
	attending (Resid	dents # O, # U, # N, # M,			timely response to all resident			
	,	L) indicated "call light			and family concerns. The			
		ong to answer)"			ED/designee is responsible for	r		
	issues (taking it	ong to answer)			conducting this in-service. In			
	Ionuoru 17th 2	012 with 10 regidents			addition, the facility will conduc	ct		
	1	012 with 10 residents			weekly Resident Council			
	,	g (Residents # O, # L, #			Meetings in order to ensure			
		$\Gamma, \# W, \# N, \# X \text{ and } \# S$)			prompt feedback and follow up			
	indicated "(Re	esident name) waits hours			from any verbalized concerns grievances. Residents with	Or		
	before call light	is answered"			grievances/concerns will be			
					queried regarding their			
	January 24, 201	2 with 6 residents signed			satisfaction to the resolution.			
	attending (Resid	dents # L, # Q, # Y, # T, #			Staff re-education with return			
		licated "call lights still			demonstrations where applica	ble		
		vered timelyweekend			and call light response			
	staff is rude"	voica minoryweekend			audits/monitoring are being			
	starr is rude				utilized to correct the alleged deficient practice. Department			
		0 14 7 11 11			managers and/or designees or			
	1	2 with 7 residents signed			random shifts and times will			
	• •	dents # Z, # L, # T, # H, #			complete audit tools and will			
	I, # U and # O)	indicated "poor care by			audit resident concerns.			
	CNA's while ba	thing (bed baths)- cold						
	rags, don't dry t	hem good, doesn't squeeze			How the corrective action(s)			
		t of rag (gets bed wet),			will be monitored to ensure t			
) was wet from 8 p.m.			deficient practice will not rec	ur,		
	`	m. before being changed."			i.e., what quality assurance program will be put into plac	· ·		
	difficulty 10 p.	m. colore come changed.			To ensure ongoing compliance			
	Eshan - 7 201	2 idb 2 ci d ci d			with this corrective action, the			
	redruary /, 201	2 with 3 residents signed			ED/designee will be responsib	le		
1	1		1					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155115	B. WIN			02/16/2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			LASALLE AVE	
CARDINA	AL NURSING AND	REHABILITATION CENTER			I BEND, IN 46617	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	attending (Resid	ents # U, # Y and # O)			for completion of the CQI Audi Tool titled, "Grievance	t
	indicated "2nd shift very slow!poor				Resolution". This tool will be	
	quality of care or	n weekends, call lights			completed daily for 4 weeks a	nd
	still not answere	d timely."			then monthly for 6 months. If	
		-			threshold of 90% is not met, a	n
	February 14 201	12 with 4 residents signed			action plan will be developed.	
	February 14, 2012 with 4 residents signed attending (Residents # M, # H, # U and #				Findings will be submitted to the	
	· ·	3 a.m. (Resident name)			CQI Committee for review and	
	· ·	` '			follow up. By what date the	
		to go to bathroom; she			systemic changes will be completed: Compliance Date	_
		er bed got changed, but			3/17/12.	
		leaned upCNA's not				
	~	when giving bed baths,				
	_ ~	n too long, (Resident				
	name) can't get a	any help in a.m. with				
	bedpan, (Reside	ent name) yells for help				
	and no one answ	vers for 1/2 hour, not				
	enough care give	en last weekend.				
		wet, (CNA name)				
	· '	wice, never changed her				
		(took about 1 hour before				
	getting changed.					
	getting changed.)				
ı	During an interv	riew with the				
	_	n 2/16/12 at 9:40 a.m.				
		eekly resident concerns,				
		was working on them, but				
	was not able to p	•				
	_	_				
		or plan for fixing the				
	ongoing problen	ns.				
ı	During an interv	riew with alert and				
ı	_	nt # H on 2/16/12 at 10:30				
		er care at night, she made				
		atement; "Last week one				
	I me monowing sta	itement, Last week one				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155115	(X2) MULTIPLE CO A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIER AL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	night I turned my call light on, they never came in for over an hour, I had to pee very bad. I hollered and yelled for help and they never came in. I have no legs so I can't help myself. I had to pee in my bed and lay in it for 2 hours When they finally came in to wash me off, they was in a hurry, so they put some soap on a rag and rubbed it over me and then dried me off never using a basin of water." Resident # H stated she called the hot line to report the poor care and lack of staff. She further indicated when she has complained to management, they just tell her they are hiring people but stated in the mean time she's not taken care of. She indicated the weekends are just as bad, the call lights are never answered. This Federal tag relates to Complaint # IN00103832. 3.1-3(1)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155115	B. WIN			02/16/2	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LASALLE AVE		
CARDINA	AL NURSING AND I	REHABILITATION CENTER			I BEND, IN 46617		
			_	<u> </u>	1 52115, 11 10017		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
F0279	483.20(d), 483.2	U(K)(1) PREHENSIVE CARE					
SS=D	PLANS	PREHENSIVE CARE					
		se the results of the					
	•	evelop, review and revise the					
		ehensive plan of care.					
	'	·					
	The facility must	develop a comprehensive					
	•	h resident that includes					
	_	ctives and timetables to					
		s medical, nursing, and					
		hosocial needs that are					
		comprehensive assessment.					
	The care plan mi	ust describe the services that					
	•	ed to attain or maintain the					
	resident's highes	t practicable physical,					
	mental, and psyc	chosocial well-being as					
		483.25; and any services					
		wise be required under					
		not provided due to the					
		se of rights under §483.10, at to refuse treatment under					
	§483.10(b)(4).	it to reluse treatment under					
		review and interview,	F02	79	F279 – Comprehensive Care		03/17/2012
			102	1)	Plans It is the practice of this		03/17/2012
	_	to ensure resident's plan			provider to use the results of the	ne l	
		updated after the			assessment to develop, review		
		elated to the residents			and revise the resident's		
	experiencing fall	s without the plan of care			comprehensive plan of care.		
	updated for 2 of	6 resident's reviewed			What corrective action(s) will	<i>1</i>	
	-	n a sample of 6. Resident			be accomplished for those		
	# F and # G	1			residents found to have beer	1	
	" I uliu " O				affected by the deficient	an	
	Findings include	-			<pre>practice: Resident F – care plants has been reviewed and update</pre>		
	i mamas merade	•			to reflect her current status	Ju	
	1 Resident # F's	record was reviewed on			related to safety and falls		
		.m. The resident's record			prevention. This resident		
					experienced no negative outco	ome	
	_	ses of, but not limited to;			as a result of this finding.		
	Osteoarthritis, de	ementia and a disorder of			Resident G – care plan has be	en	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A ВІП	LDING	00	COMPLETED	
		155115	A. BUI B. WIN			02/16/2012	
		1	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER			1 BEND, IN 46617		
					T		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG			
	the bone and car	tilage.			reviewed and updated to refle her current status related to	J Cl	
					safety and falls prevention. T	This	
	The resident's qu	uarterly MDS (Minimum			resident experienced no nega		
	Data Set) assess	ment dated 12/2/11			outcome as a result of this		
	indicated her co	gnition was moderately			finding. How other residents		
		as total assistance with 2			having the potential to be		
		transfers, ambulation,			affected by the same deficie		
		ing. The MDS further			practice will be identified ar		
	l •	•			what corrective action(s) wi		
	indicated she was incontinent of both bowel and bladder function.				be taken: All residents who experience a fall have the		
					potential to be affected by this	s	
					finding. A facility audit will be		
	The resident's re	ecord indicated she had			conducted by the Nurse		
	fallen on 2/09/11	2 at 4:15 a.m. A nurses			Management Team. This au	dit	
	note documente	d on 2/9/12 at 4: 28 a.m.			will review all fall care plans f		
		ent found on floor beside			those residents with falls dati	•	
		njury noted, neuro checks			back to 1/1/12. The audit will		
		nin normal limits) vs			ensure that these residents haccurate and updated care pl		
	` `	,			and that fall care plans have		
		, no signs of pain or			updated with a new interventi		
		fall, will have days			post fall. Any discrepancies		
		to be put in place to help			be clarified and corrected at t	the	
	prevent further f	falls."			time noted. In addition, the II	DT	
					will review falls during daily		
	The resident's pl	an of care dated 2/2/12			clinical meetings to ensure	70	
	_	em; Resident is at risk for			appropriate interventions wer initiated post fall and to ensur		
		physical functioning,			care plans and Nurse Aide		
		y of) falls" The plan of			Assignment Sheets have bee	en	
	• • •	clude the bed alarm.			updated accordingly. The on		
	care failed to file	ride the bed alailii.			nurse will be notified promptly	y	
	D	: :4.4. NDC			after any fall event to ensure		
	During an interview with the MDS coordinator # 4, on 2/16/12 at 8:00 a.m.				appropriate interventions are		
					initiated. What measures w	VIII	
	she indicated the	e alarm was noted in the			be put into place or what systemic changes will be m	nado	
IDT (interdisciplinary team) notes and not the plan of care.		linary team) notes and not			to ensure that the deficient	aue	
				practice does not recur: A			
					nursing in-service will be		
	l						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155115	A. BUI. B. WIN			02/16/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹				
CARRINI	AL AULIDOING AND	DELLA DIL ITATIONI OFNITED			LASALLE AVE	
CARDIN	AL NURSING AND	REHABILITATION CENTER		5001H	I BEND, IN 46617	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	IDT note dated 2	2/13/12 at 10:53 a.m.			conducted by the DNS/design	ee
	indicated the res	ident was found on the			on 3/6/12. This in-service will	
	floor again and received a skin tear to her				include review of the policy title	ed,
	right hand and a hematoma to her				"Fall Management Program". This in-service will also include	
	_	sident had been sent to			review of the procedure relate	
					post fall review and	
	I	oom for an evaluation			documentation including	
	_	1. The plan of care failed			reviewing and updating the fal	ls
	to include an upo	date for the 2/11/12 fall.			care plan and Nurse Aide	
					Assignment Sheet promptly af	
	2. Resident G's	record was reviewed on			any fall event. In addition, the	· · · · · · · · · · · · · · · · · · ·
	2/16/12 at 7:00 a	.m. The resident's record			IDT will review falls during dail clinical meetings to ensure all	У
	indicated diagno	ses of, but not limited to;			care plans are updated with ne	<i>⊃\</i> \\
	_	betes, obesity, kidney			and appropriate interventions	
		ebral vascular accident.			after any fall event. The on-ca	all
	disease, and cere	total vascular accident.			nurse will be notified promptly	
					after any fall event to ensure	
		DS indicated her			appropriate interventions are	
	cognition was m	oderately impaired and			initiated. Daily nursing rounds	
	needed extensive	e assistance with bed			be conducted to ensure safety	
	mobility and 2 st	taff. The resident needed			interventions are in place per individual resident care plan.	
	extensive assista	nce with transfers and			How the corrective action(s)	
	dressing and was	s incontinent of bowel			will be monitored to ensure to	the
	and bladder func				deficient practice will not red	
	and bladder rune	Alon.			i.e., what quality assurance	
	701 11 41	1: 1: 4 1 1 1 1			program will be put into plac	e:
		cord indicated she had an			The CQI Audit tool titled, "Care	e
		on 2/7/12 at 10:45 p.m.			Plan Updating" and will be	
		1 2/8/12 at 3:00 a.m.			completed weekly x 4 weeks,	the
	indicated " reside	ent was found on floor			then monthly for 6 months by the MDS Coordinator/designee. It	· · · · · · · · · · · · · · · · · · ·
	beside bed wrap	ped in comforter and bed			threshold of 90% is not met, a	· · · · · · · · · · · · · · · · · · ·
	sheet. Resident states when she was				action plan will be developed.	
	reaching for something on bedside table				Findings will be submitted to the	ne
	she started sliding and slid right out of				CQI Committee for review and	
		ig and shu right but br			follow up.	
	bed"				Daily rounds will be conducted on a	II
					shifts by nurse managers or	
	The resident's pl	an of care dated 12/23/12			designees.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155115		LDING	00	COMPLI 02/16/2	
		100110	B. WIN		DDDECC CITY OTHER OFF	02/10/	<u> </u>
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE		
		REHABILITATION CENTER			BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	indicated "Proble fall due to impai incontinence, Do (cerebral vascula residents plan of had been updated intervention to p	em, Resident is at risk for		TAG	By what date the systemic changes will be completed: Compliance Date = 3/17/12.	TE	DATE
ı							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 995N11

Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155115	B. WIN			02/16/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				LASALLE AVE		
CADDINI	AL NITIDGING AND I	REHABILITATION CENTER			H BEND, IN 46617		
				30011	BEND, IN 40017		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323	483.25(h)						
SS=D	FREE OF ACCID						
		ERVISION/DEVICES					
	-	ensure that the resident rains as free of accident					
		ssible; and each resident					
	•	te supervision and					
	-	es to prevent accidents.					
		ew and record review, the	F03	23	F323 - Free of Accident		03/17/2012
		provide necessary			Hazards/Supervision It is the		
		sure 2 residents who			practice of this provider to ens	ure	
	•	for falling (Residents #			that the resident environment remains as free of accident		
	_	• •			hazards as is possible; and that	at	
	F and # G) were protected from falls for 2 of 2 residents reviewed for falls in a				each resident receives adequa		
		riewed for fails in a			supervision and assistive device		
	sample of 6.				to prevent accidents. What		
					corrective action(s) will be		
	Findings include	:			accomplished for those		
					residents found to have been	n	
	During an intervi	iew with CNA # 3 on			affected by the deficient		
	2/16/12 at 4:15 a	.m. she indicated she			practice: Resident F has		
	works alone with	47 to 49 residents most			experienced no further falls. A safety inspection of this reside		
	of the time. She	indicated when she			room has been completed by t		
	comes to work at	t 10:00 p.m. there's just			IDT. The care plan and Nurse		
		scheduled on the 1st			Aide Assignment Sheet have		
	floor CNA # 3 i	indicated sometimes they			been reviewed and updated to)	
		rson come in at 4:00 a.m.			reflect all current safety interventions. Resident G has		
	•	ng people up. She			experienced no further falls. A	<u>ا</u>	
					safety inspection of this reside		
		when she comes to work			room has been completed by t		
	•	e call lights are going off			IDT. The care plan and Nurse	;	
		any of the residents are 2			Aide Assignment Sheet have		
	person assist for	care and transfers and			been reviewed and updated to)	
	they can't get to t	the other residents on			reflect all current safety		
	time and they fal	l or wet themselves.			interventions. How other residents having the potential	, l	
	CNA # 3 and LP	N # 5 both indicated			to be affected by the same	ai	
		llen because there wasn't			deficient practice will be		
					identified and what correctiv	e	

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Event ID: 995N11

Facility ID: 000048

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLI	ETED
		155115	B. WIN			02/16/	2012
			J. (11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWINED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	enough staff to a	assist them on time. LPN			action(s) will be taken: All		
	_	sident # F and # G both			residents identified as being a	t	
		ng the night shift with 1			risk for falls have the potential	to	
	CNA scheduled.	-			be affected by this finding. A		
	CNA scheduled.				facility audit will be completed		
					the Nurse Management Team This audit will ensure that all		
		record was reviewed on			residents identified as being a	,	
	2/16/12 at 6:00 a	a.m. The resident's record			risk for falls have appropriate	·	
	indicated diagno	ses of, but not limited to;			safety interventions in place to		
	Osteoarthritis, an	nd a disorder of the bone			prevent falls and accidents. T		
	and cartilage.				Nurse Aide Assignment Sheet	s	
	una varanago.				will be checked against each		
	The regident's a	uarterly MDS (Minimum			resident's fall care plan to ens	ure	
	_	• ,			all safety interventions are in		
		ment dated 12/2/11			place. In addition, resident root safety inspections will be	om	
		gnition was moderately			completed to ensure all safety		
	impaired, she wa	as total assistance with 2			interventions are in place. Fa		
	or more staff for	transfers, ambulation,			Risk Assessments will be		
	eating, and bathi	ing. The MDS further			completed on admission,		
	•	is incontinent of bowel			quarterly, annually and with ar		
	and bladder fund				significant change in condition		
					Resident specific fall prevention	n	
	The medianale me	cord indicated she had			interventions are initiated and		
					communicated to all caregiver when any assessment identified		
		2 at 4:15 a.m. A nurses'			resident at risk for falls. What		
		d on 2/9/12 at 4: 28 a.m.			measures will be put into pla		
	indicated " resid	ent found on floor beside			or what systemic changes w		
	bed on mat, no is	njury noted, neuro checks			be made to ensure that the		
	started wnl (with	nin normal limits) vs			deficient practice does not		
	`	, no signs of pain or			recur: A nursing in-service wil	lbe	
	`	fall, will have days			conducted on 3/6/12. This	,	
		to be put in place to help			in-service will include review o	†	
					the policy titled, "Fall Management Program". This		
	prevent further f	ans.			in-service will also include revi	ew	
					of falls prevention intervention		
	•	an of care dated 2/2/12			and the importance of timely	-	
	indicated "Probl	em; Resident is at risk for			response to resident call lights		
	fall due to: poor	physical functioning,			and careful attention to the Nu	rse	

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Event ID: 995N11

Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155115	B. WIN			02/16/2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	L.				
CADDIN	AL NUIDCING AND	DELIADII ITATIONI CENTED			LASALLE AVE	
CARDIN	AL NURSING AND	REHABILITATION CENTER		S001F	I BEND, IN 46617	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	aging, hx (histor	y of) falls" The plan of			Aide Assignment Sheets to	
		lude the bed alarm.			ensure all resident specific saf	ety
		rade the sea thann.			interventions are in place to	
	D	: :4.4 NDC			prevent falls. Falls will be	
	_	iew with the MDS			thoroughly reviewed in the dail	ly
	-	on 2/16/12 at 8:00 a.m.			clinical meeting to ensure	
	she indicated the	alarm was noted in the			appropriate interventions were	
	IDT (interdiscipl	inary team) notes and not			initiated post fall and to ensure care plans and Nurse Aide	;
	the plan of care.	- /			Assignment Sheets have beer	,
					updated accordingly. Daily	'
	 IDT :: -4- d-4-d 2	0/12/12 -4 10.52			nursing rounds will be conduct	ed
		2/13/12 at 10:53 a.m.			to ensure safety interventions	
		ident was found on the			in place per individual resident	
	floor again and r	eceived a skin tear to her			care plan. Fall Risk Assessme	ents
	right hand and a	hematoma to her			will be completed on admission	•
	forehead. The re-	sident had been sent to			quarterly, annually and with ar	-
	the emergency ro	oom for an evaluation			significant change in condition	
		l. The plan of care failed			Resident specific fall prevention	on
	_	-			interventions are initiated and communicated to all caregivers	
	to include an upo	late for the 2/11/12 fall.			when any assessment indentif	
					a resident at risk for falls. How	
	2. Resident G's	record was reviewed on			the corrective action(s) will be	
	2/16/12 at 7:00 a	.m. The resident's record			monitored to ensure the	
	indicated diagno	ses of, but not limited to;			deficient practice will not red	eur,
		betes, obesity, kidney			i.e., what quality assurance	
		bral vascular accident.			program will be put into plac	e:
	discuse, and cere	orar vascular accident.			To ensure ongoing compliance	•
		DG: 1: 11			with this corrective action, the	
		DS indicated her			DNS/designee will complete the	ne
	_	oderately impaired and			CQI Audit tool titled, "Fall	
	needed extensive	e assistance with bed			Management". This tool will be	
	mobility and 2 st	aff. The resident needed			completed weekly for 4 weeks and monthly for 6 months. If	
	1	nce with transfers and			threshold of 90% is not met, a	n
		s incontinent of bowel			action plan will be developed.	
	and bladder func				Data will be submitted to the C	QI
	and bladder lunc	HOII.			Committee for review and follo	
					up.Daily rounds will be conduc	ted
	The resident's re-	cord indicated she had an			on all shifts by nurse manager	s or
	unwitnessed fall	on 2/7/12 at 10:45 p.m.			designees. By what date the	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	00		COMPLETED	
		155115	A. BUILDING B. WING		02/16	8/2012
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP LASALLE AVE I BEND, IN 46617	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Nurse note dated indicated " reside beside bed wrapp sheet. Resident's reaching for som she started slidin bed" The resident's plaindicated "Proble fall due to impair incontinence, Dx (cerebral vascular During an intervence of 2/16/12 at 4:30 at residents who has she stated "Residents who has she stated "Residents who has he sta	2/8/12 at 3:00 a.m. ent was found on floor bed in comforter and bed fates when she was ething on bedside table g and slid right out of em, Resident is at risk for red mobility, (diagnosis) Hx of CVA er accident). few with CNA # 6 on em. regarding the d fallen on night shift, lent # G fell because we to her in time. When ling and complaining the bedpan or need water 1 CNA, they wind up me, wetting themselves		CROSS-REFERENCED TO THE	ill be	
	IN00103832.	relates to Complaint #				
	3.1-45(2)					

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Event ID: 995N11

Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/16/2012
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET 1121 E	ADDRESS, CITY, STATE, ZIP CODE E LASALLE AVE H BEND, IN 46617	
	SUMMARY S' (EACH DEFICIEN REGULATORY OR 483.30(a) SUFFICIENT 24 CARE PLANS The facility must to provide nursin attain or maintain physical, mental of each resident, assessments and The facility must sufficient numbe types of personn provide nursing of accordance with Except when wa this section, licer nursing personn Except when wa this section, the	REHABILITATION CENTER FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) -HR NURSING STAFF PER have sufficient nursing staff g and related services to n the highest practicable and psychosocial well-being as determined by resident d individual plans of care. provide services by rs of each of the following el on a 24-hour basis to care to all residents in resident care plans: ived under paragraph (c) of nsed nurses and other el. ived under paragraph (c) of facility must designate a p serve as a charge nurse on	ID PREFIX TAG	LASALLE AVE	DATE
	record review, the there was sufficient for residents related and 1 nurse scheut 47 residents result had fallen during 1 resident who had lay in it due and 1 resident obtained for 5 minutes. The potential to a	ation, interviews and e facility failed to ensure ent nursing staff to care ted to 1 nursing assistant duled at night to care for liting in 2 residents who the night shift, and for ad to urinate in her bed to lack of sufficient staff, eserved yelling for help his deficient practice had ffect 4 of 6 residents in sidents # F, # G, # J and #	F0353	F353 – Sufficient 24-Hour Staff Per Care Plans It is the practice of this provider to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident F – care plan has been reviewed and updated to reflect here	5

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Event ID: 995N11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00		COMPLETED	
		155115	B. WIN			02/16/2012	
NAME OF T	DOMDED OF GUIDNASE				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t .		1121 E	LASALLE AVE		
		REHABILITATION CENTER		SOUTH BEND, IN 46617			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	ì ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	
	Findings include				current status related to safety and		
					falls prevention. This resident		
	During a night sl	hift tour of the facility on			experienced no negative outcome a	IS	
	2/16/12 at 3:50 a	.m. accompanied by LPN			a result of this finding. There is	,	
	# 5, he indicated	there were 2 CNA's on			adequate staff to provide necessary care and services to this resident.		
	· ·	this night shift, but most			Resident G - care plan has been		
		orks with only 1 CNA for			reviewed and updated to reflect he	r	
		s. LPN # 5 indicated			current status related to safety and		
					falls prevention. This resident		
	*	t, but care does suffer			experienced no negative outcome a	IS	
		ot enough staff to care			a result of this finding. There is		
	for this many res	sidents.			adequate staff to provide necessary	,	
					care and services to this resident.		
	During a continu	ed interview with LPN #			Resident J – experienced no		
	5, he indicated h	e has been working on			negative outcome as a result of this		
	· ·	almost a month with 1			finding. There is adequate staff to		
		ed it has become the			provide necessary care and services	i	
	•	re there 2 aides and there			to this resident.		
	has been 47 to 48				Resident H – experienced no		
	nas been 47 to 4	o residents.			negative outcome as a result of this		
					finding. There is adequate staff to		
	_	iew with CNA # 3 on			provide necessary care and services to this resident.	'	
		.m. she indicated she			How other residents having the		
	works alone with	n 47 to 49 residents most			potential to be affected by the		
	of the time. She	indicated when she			same deficient practice will be		
	comes to work a	t 10:00 p.m. there's just			identified and what corrective		
		e scheduled on the 1st			action(s) will be taken:		
		indicated sometimes they			All residents have the potential to b	e	
		rson come in at 4:00 a.m.			affected by this finding. Nursing		
	_	ing people up. She			schedules and staffing ratios are		
		when she comes to work			reviewed daily. The DNS/designee	is	
					responsible for ensuring adequate		
	_	e call lights are going off			and sufficient nursing staff to		
		nany of the residents are 2			provide care to all residents.		
	person assist for	care and transfers and			What measures will be put into	,,	
	they can't get to	the other residents on			place or what systemic changes will be made to ensure that the	u	
	time and they fal	ll or wet themselves.			be made to ensure that the		

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Event ID: 995N11

Facility ID: 000048

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			TED	
		155115	A. BUII B. WIN			02/16/2	012
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		l	LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		SOUTH BEND, IN 46617			
	T						
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
		PN # 5 both indicated			deficient practice does not recur:		
	residents have fa	allen because there wasn't			A nursing in-service is scheduled fo	r	
	enough staff to a	assist them on time. LPN			3/6/12. The ED/DNS/designee is responsible for conducting this		
	# 5 indicated Re	sident # F and # G both			in-service. This in-service will		
	have fallen durii	ng the night shift with 1			include review of staffing patterns		
	CNA scheduled				and required staffing ratios to		
					provide nursing and related service	s	
	Continued interv	view with CNA # 3			to all residents. The charge nurses		
		ng alone with 47 to 49			will be instructed to contact the		
		licated there are 3			on-call nurse in the event that there	e	
					is a change in the scheduled staffing	g	
		n the 1st floor and she's			for any shift. The on-call nurse		
		t everyone in a reasonable			rotation will ensure sufficient		
	time. CNA # 3 i	ndicated the nurse helps			staffing and adequate coverage at a		
	when they're abl	e to, but they have their			times. The nurse management team	m	
	job to do and ca	n't always help out.			will provide direct care coverage if		
					needed in order to ensure sufficien	t	
	1. During obser	vation on 2/16/12 at 4:40			staffing coverage. The Nurse Management Team will meet daily		
	1	Resident # J) was			to review staffing/scheduling to		
	,	up on the edge of her bed			ensure adequate coverage.		
	_				How the corrective action(s) will b	e l	
	_	elp. CNA # 3 and LPN #			monitored to ensure the deficient		
		busy in other resident			practice will not recur, i.e., what		
		ninutes, CNA # 3 heard			quality assurance program will be		
		esident and ran out of the			put into place:		
		to assist the screaming			To ensure ongoing compliance with	n	
	resident before s	she fell. CNA # 3			this corrective action, the		
	indicated if she	hadn't been close enough			DNS/designee will be responsible for	or	
	to hear her, she	would have fallen out of			completion of the CQI Audit tool		
	· ·	⁴ 3 indicated she's not able			titled, "Staffing Patterns/Scheduling	g"	
		all lights for up to 2 hours			daily for 4 weeks then 3 times	, l	
	_	oing off on the other halls.			weekly for 6 months. If threshold of 100% is not met, an action plan will		
	when they are g	ome on on the other name.			be developed.	'	
	2 Pagidant # Ele	s record was reviewed on			By what date the systemic change	es	
					will be completed:		
		a.m. The resident's record			Compliance Date = 3/17/12.		
	indicated diagno	oses of, but not limited to;					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155115	B. WING		02/16/2012	
NAME OF F	DOMINED OF CLIPPLIES	D		ADDRESS, CITY, STATE, ZIP CODE	•	
INAME OF F	PROVIDER OR SUPPLIEI	N.		LASALLE AVE		
	AL NURSING AND	REHABILITATION CENTER	SOUT	SOUTH BEND, IN 46617		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	``	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE	
TAG		nd a disorder of the bone	TAG		DATE	
	•	ind a disorder of the bolle				
	and cartilage.					
	The resident's a	uarterly MDS (Minimum				
		ment dated 12/2/11				
	· · · · · · · · · · · · · · · · · · ·	gnition was moderately				
		as total assistance with 2				
	-	transfers,, ambulation,				
		ing. The MDS further				
	J C	as incontinent of bowel				
	and bladder fund					
	The resident's re	ecord indicated she had				
	fallen on 2/09/12	2 at 4:15 a.m. A nurses				
	note documented	d on 2/9/12 at 4: 28 a.m.				
	indicated " resid	ent found on floor beside				
	bed on mat, no i	njury noted, neuro checks				
	started wnl (with	nin normal limits) vs				
	`	, no signs of pain or				
		fall, will have days				
		to be put in place to help				
	prevent further f	falls."				
	TT 1 4 4	C 1 4 10/0/10				
		an of care dated 2/2/12				
		em; Resident is at risk for				
		physical functioning,				
		ry of) falls" The plan of				
	care raned to inc	clude the bed alarm.				
	During an interv	view with the MDS				
	_	on 2/16/12 at 8:00 a.m.				
	· · · · · · · · · · · · · · · · · · ·	e alarm was noted in the				
		linary team) notes and not				
	the plan of care.	-				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		A. BUILDING B. WING		COMPLETED 02/16/2012
	PROVIDER OR SUPPLIER AL NURSING AND REHABILITATION CENTER	STREET ADDRES 1121 E LASA SOUTH BENI		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	IDT note dated 2/13/12 at 10:53 a.m. indicated the resident was found on the floor again and received a skin tear to her right hand and a hematoma to her forehead. The resident had been sent to the emergency room for an evaluation following the fall. The plan of care failed to include an update for the 2/11/12 fall. 3. Resident G's record was reviewed on 2/16/12 at 7:00 a.m. The resident's record indicated diagnoses of, but not limited to; Uncontrolled diabetes, obesity, kidney disease, and cerebral vascular accident. The resident's MDS indicated her cognition was moderately impaired and needed extensive assistance with bed mobility and 2 staff. The resident needed extensive assistance with transfers and dressing and was incontinent of bowel and bladder function. The resident's record indicated she had an unwitnessed fall on 2/7/12 at 10:45 p.m. Nurse note dated 2/8/12 at 3:00 a.m. indicated " resident was found on floor beside bed wrapped in comforter and bed sheet. Resident states when she was reaching for something on bedside table she started sliding and slid right out of bed"			

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Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155115	B. WIN	G		02/16/2	2012
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1121 E	LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		SOUTH	BEND, IN 46617		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	an of care dated 12/23/10					
		em, Resident is at risk for					
	fall due to impai	•					
	incontinence, Dx	x (diagnosis) Hx of CVA					
	(cerebral vascula	r accident).					
	During an interv	iew with CNA # 6 on					
	2/16/12 at 4:30 a	.m. regarding the					
	residents who ha	d fallen on night shift,					
	she stated "Resid	lent # G fell because we					
	just couldn't get	to her in time. When					
	l "	ling and complaining					
	1 -	ne bedpan or need water					
		1 CNA, they wind up					
	<u> </u>	me, wetting themselves					
	1	# 6 indicated they have					
		anagement but all they					
	say is they're wo	•					
	say is they le wo	rking on it.					
	Review of the fa	cility staffing schedule on					
	2/16/12 at 9:45 a	.m. indicated on the					
	following night s	shifts on the 1st floor					
		nurse and 1 CNA					
	scheduled:						
	January 1st 10 p	o.m. until 2:00 a.m. for 49					
	residents						
	January 5th-10 p	.m. until 4:00 a.m. for 46					
	residents						
	January 10th-10	p.m. until 4:00 a.m. for					
	47 residents						
	January 11th-10	p.m. until 4:00 a.m. for					
	47 residents						
	January 14th-10	p.m. until 4:00 a.m. for					
	I -	-	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155115	B. WIN	G		02/16/2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					LASALLE AVE	
CARDIN	AL NURSING AND	REHABILITATION CENTER		SOUTH	BEND, IN 46617	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	47 residents					
	1	a.m. until 4:00 a.m. for 48				
	residents					
	_	a.m. until 4:00 a.m. for				
	47 residents					
	I -	p.m. until 4:00 a.m. for				
	48 residents					
	_	p.m. until 2:00 a.m. for				
	48 residents					
	January 22nd-10	p.m. until 4:00 a.m. for				
	48 residents					
	January 23rd- 10	p.m. until 4:00 a.m. for				
	48 residents					
	January 24th- 10	p.m. until 4:00 a.m. for				
	47 residents					
	January 30th- 10	p.m. until 4:00 a.m. for				
	46 residents					
	January 31st- 10	p.m. until 4:00 a.m. for				
	45 residents					
	For the month of	February 2012 the				
	following night s	shifts on the 1st floor				
	indicated there w	vas only 1 nurse and 1				
	CNA scheduled;					
	February 2nd fro	om 10 p.m. until 4:00 a.m.				
	for 48 residents					
	February 4th from	m 10 p.m. until 4:00 a.m.				
	for 47 residents	-				
	February 7th from	m 10 p.m. until 2:00 a.m.				
	for 47 residents	•				
		m 10 p.m. until 4:00 a.m.				
	for 47 residents	1				
		m 10 p.m. until 4:00 a.m.				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL: 02/16/	ETED	
NAME OF I	PROVIDER OR SUPPLIE		B. WIN		DDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER			LASALLE AVE BEND, IN 46617		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	DATE
	for 48 residents						
	February 10th fr	om 10 p.m. until 4:00					
	a.m. for 48 resid						
	I -	om 10 p.m. until 4:00					
	a.m. for 46 resid	lents					
	1 -	om 10 p.m. until 4:00					
	a.m. for 46 resid						
	1 -	om 10 p.m. until 4:00					
	a.m. 46 resident	S					
	During an interv	view with the staff					
	responsible for s	scheduling the shifts on					
	2/16/12 at 10:00	a.m. she indicated there					
	should be 2 CN	A's and a nurse scheduled					
	for night shift ar	nd when we can't we try					
	and have a CNA	come in at 4:00 a.m. but					
	it still leaves the	floor with only 1 nurse					
	and 1 CNA fron	n 10 p.m. until 4:00 a.m.					
	During an interv	view with the					
	Administrator of	n 2/16/12 at 10:10 a.m.					
	1 -	ck of sufficient staff for					
		ng unsafe he indicated he					
	agreed that there	e should have been 2					
	CNA's for that n	nany residents.					
	4. During an into	erview with alert and					
	oriented Resider	nt # H on 2/16/12 at 10:30					
	a.m. regarding h	er care at night, she made					
	_	atement; "Last week one					
	night I turned m	y call light on, they never					
	came in for over	an hour, I had to pee					
	very bad. I holle	ered and yelled for help					
	and they never o	came in. I have no legs so					

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	DF CORRECTION IDENTIFICATION NUMBER: 155115	A. BUILDING B. WING	COMPLETED 02/16/2012
	ROVIDER OR SUPPLIER AL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	I can't help myself. I had to pee in my bed and lay in it for 2 hours. When they finally came in to wash me off, they was in a hurry, so they put some soap on a rag and rubbed it over me and then dried me off never using a basin of water." Resident # H stated she called the hot line to report the poor care and lack of staff. She further indicated when she has complained to management, they just tell her they are hiring people but stated in the mean time she's not taken care of. She indicated the weekends are just as bad, the call lights are never answered. This Federal tag relates to Complaint # IN00103832. 3.1-17(a) 3.1-17(b)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING O		(X3) DATE SURVEY COMPLETED
155115		B. WING		02/16/2012	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
CARDINAL NURSING AND REHABILITATION CENTER 1121 E LASALLE AVE SOUTH BEND, IN 46617					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		

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